BlueCross BlueShield of Illinois

Blue Cross Group Medicare Advantage Open Access (PPO)[SM] offered by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC)

Annual Notice of Changes for 2022

You are currently enrolled as a member of Blue Cross Group Medicare Advantage Open Access (PPO)[SM] through DePaul University. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **During your Group's open enrollment period, you may make changes to your Medicare coverage for next year.**

What to do now

1. **ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1.6 for information about changes to our drug coverage.

- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 2.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan
   - If you don't join another plan, you will be enrolled in Blue Cross Group Medicare Advantage Open Access (PPO).
   - To change to a **different plan** that may better meet your needs, contact your Employer Group Plan Benefit Administrator.
4. **ENROLL: To change plans, you may join a plan during your Open Enrollment Period. Contact your Benefit Administrator for details.**

Additional Resources

- This document is available for free in Spanish.
- ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call Customer Service at 1-877-299-1008 (TTY only, call: 711) for more information.
- ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicio al Cliente al 1-877-299-1008 (TTY: 711) para recibir más información.
- Please contact our Customer Service number at 1-877-299-1008 for additional information. (TTY users should call 711). Hours are 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
- Para obtener más información por favor póngase en contacto con nuestro número de servicio al cliente en 1-877-299-1008. (Usuarios de TTY deben llamar al 711). El horario es de 8:00 – 20:00, hora de local, 7 días a la semana. Si usted está llamando desde el 1 de abril hasta el 30 de septiembre, tecnologías alternativas (por ejemplo, correo de voz) se utilizarán los fines de semana y festivos.
- Please contact Blue Cross Group Medicare Advantage Open Access (PPO) if you need this information in another language or format (Spanish, braille, large print or alternate formats).
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Blue Cross Group Medicare Advantage Open Access (PPO)

- PPO plans provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in HCSC's plans depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). When it says "plan" or "our plan," it means Blue Cross Group Medicare Advantage Open Access (PPO).

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Blue Cross Group Medicare Advantage Open Access (PPO) in several important areas. **Please note this is only a summary of changes**. You may call Customer Service to ask us to mail you an *Evidence of Coverage*. **It is important to read the rest of this *Annual Notice of Changes*** and review the *Evidence of Coverage Benefits Insert* to see if other benefit or cost changes affect you.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	**You can get information regarding your premium by going through your employer group.**	
Deductible	$200 for in-network and out-of-network medical services with a coinsurance.	$200 for in-network and out-of-network medical services with a coinsurance.
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	From network and out-of-network providers combined: $1,000	From network and out-of-network providers combined: $1,000
Doctor office visits	**Primary care visits:** In-Network: $20 copay Out-of-Network: $20 copay **Specialist visits:** In-Network: $40 copay Out-of-Network: $40 copay	**Primary care visits:** In-Network: $20 copay Out-of-Network: $20 copay **Specialist visits:** In-Network: $40 copay Out-of-Network: $40 copay

Cost	2021 (this year)	2022 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	In-Network: 4% of the total cost per stay Out-of-Network: 4% of the total cost per stay	In-Network: 4% of the total cost per stay Out-of-Network: 4% of the total cost per stay
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: **Drug Tier 1:** 20% ($10 min; $100 max) **Drug Tier 2:** 20% ($10 min; $100 max) **Drug Tier 3:** 20% ($10 min; $100 max) **Drug Tier 4:** 20% ($10 min; $100 max) **Drug Tier 5:** 20% ($10 min; $100 max)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: **Drug Tier 1:** 20% ($10 min; $100 max) **Drug Tier 2:** 20% ($10 min; $100 max) **Drug Tier 3:** 20% ($10 min; $100 max) **Drug Tier 4:** 20% ($10 min; $100 max) **Drug Tier 5:** 20% ($10 min; $100 max)

Annual Notice of Changes for 2022
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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	**You can get information regarding your premium by going through your employer group.**	

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 5 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2021 (this year)	2022 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$1,000	$1,000 Once you have paid $1,000 out-of-pocket for covered services, you will pay nothing for your covered services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our Blue Access for Members (BAM) portal (www.bluememberIL.com). You may also call Customer Service for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.

- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated *Pharmacy Directory* is located on our Blue Access for Members (BAM) portal (www.bluememberIL.com). You may also call Customer Service for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2022 *Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your 2022 *Evidence of Coverage Benefits Insert.*

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Other Health Care Professional Services	In-Network: $40 copay Out-of-Network: $40 copay	In-Network: $20 copay/PCP $40 copay/SPC Out-of-Network: $20 copay/PCP $40 copay/SPC
Urgently Needed Services (Worldwide)	In-Network: $65 copay Out-of-Network: $65 copay	In-Network: $40 copay Out-of-Network: $40 copay
OP Blood Services	In-Network: 4% Coverage begins with the 4th pint of blood Out-of-Network: 4% Coverage begins with the 4th pint of blood	In-Network: 4% Coverage begins with the 1st pint of blood Out-of-Network: 4% Coverage begins with the 1st pint of blood

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." Our Drug List is located on our Blue Access for Members (BAM) portal (www.bluememberIL.com). The Drug List we provide includes many – but not all – of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You can get the *complete* Drug List** by calling Customer Service (see the back cover) or visiting our Blue Access for Members (BAM) portal.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
  - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Service.

- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Current formulary exceptions may still be covered, depending on the circumstance. You can call Customer Service to confirm coverage duration.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. Because you receive "Extra Help" and didn't receive this insert with this packet, please call Customer Service and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage Benefits Insert* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage Benefits Insert.* You may call Customer Service to ask us to mail you an *Evidence of Coverage Benefits Insert*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in your *Evidence of Coverage Benefits Insert*. We changed the tier for some of the drugs on our Drug List. To	Your cost for a one-month supply at a network pharmacy with standard cost sharing: **Tier 1: Preferred Generic:** • You pay 20% ($10 min; $100 max) per prescription. **Tier 2: Generic:** • You pay 20% ($10 min; $100 max) per prescription. **Tier 3: Preferred Brand:** • You pay 20% ($10 min; $100 max) per prescription. **Tier 4: Non-Preferred Drug:** • You pay 20% ($10 min; $100 max) per prescription.	Your cost for a one-month supply at a network pharmacy with standard cost sharing: **Tier 1: Preferred Generic:** • You pay 20% ($10 min; $100 max) per prescription. **Tier 2: Generic:** • You pay 20% ($10 min; $100 max) per prescription. **Tier 3: Preferred Brand:** • You pay 20% ($10 min; $100 max) per prescription. **Tier 4: Non-Preferred Drug:** • You pay 20% ($10 min; $100 max) per prescription.

Stage	2021 (this year)	2022 (next year)
see if your drugs will be in a different tier, look them up on the Drug List.	**Tier 5: Specialty:** • You pay 20% ($10 min; $100 max) per prescription. Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	**Tier 5: Specialty:** • You pay 20% ($10 min; $100 max) per prescription. Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage Benefits Insert*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Blue Cross Group Medicare Advantage Open Access (PPO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by the open enrollment timeframe as defined by your employer, you will automatically be enrolled in our Blue Cross Group Medicare Advantage Open Access (PPO).

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,

- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.** Your coverage is provided through a contract with your current employer or former employer or union. Please contact your employer/union benefits administrator for more information on opting out.

Step 2: Change your coverage

- If you no longer wish to be covered by Blue Cross Group Medicare Advantage Open Access (PPO), please contact your employer/union benefits administrator.
- If you want to enroll in an Individual (retail) Medicare Advantage plan, the Centers for Medicare and Medicaid Services (CMS) will automatically disenroll you from your Blue Cross Group Medicare Advantage Open Access (PPO) plan.
- If you want to **change to Original Medicare without a prescription drug plan**, you must either:
  - Contact your current employer or former employer or union.
  - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it during your Group's specified Open Enrollment period. Contact your Employer Group Plan Benefit Administrator to understand what happens if you disenroll from the group plan. The change will take effect on January 1, 2022.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2022, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage). For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*. Your coverage is provided through a contract with your current employer or former employer or union. Please contact your employer/union benefits administrator for more information.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Illinois, the SHIP is called Illinois Department on Aging.

Illinois Department on Aging is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Illinois Department on Aging counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Illinois Department on Aging at 1-800-252-8966. You can learn more about Illinois Department on Aging by visiting their website (https://www2.illinois.gov/aging/ship/Pages/default.aspx). If you need assistance in another state please visit www.bcbsil.com/retiree-medicare-tools for a listing of SHIP's in every state.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).

- **State Pharmaceutical Assistance Program (SPAP).** Some states have SPAP's that help people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about these programs, check with your State Health Insurance Assistance Program. To obtain a listing of the program in your state please visit www.bcbsil.com/retiree-medicare-tools.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Illinois Department of Public Health, 535 W. Jefferson St. First Floor, Springfield, IL 62761; https://dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-217-782-4977. If you need assistance in another state please visit www.bcbsil.com/retiree-medicare-tools for a listing of ADAP's in every state.

SECTION 6 Questions?

Section 6.1 – Getting Help from Blue Cross Group Medicare Advantage Open Access (PPO)

Questions? We're here to help. Please call Customer Service at 1-877-299-1008. (TTY only, call 711). We are available for phone calls 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. Calls to these numbers are free.

Read your 2022 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 *Evidence of Coverage Benefits Insert* for Blue Cross Group Medicare Advantage Open Access (PPO). The *Evidence of Coverage Benefits Insert* is the legal, detailed description of your plan benefits. In addition, the *Evidence of Coverage booklet* explains your rights and the rules you need to follow to get covered services and prescription drugs. The *Evidence of Coverage* and the *Evidence of Coverage Benefits Insert* is located on our Blue Access for Members (BAM) portal (www.bluememberIL.com) or you may call Customer Service to ask us to mail you a copy.

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare.)

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Group Medicare Advantage Open Access (PPO) members, except in emergency situations. Please call our customer service number or see your *Evidence of Coverage Benefits Insert* for more information, including the cost sharing that applies to out-of-network services.